STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555764	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palomar Heights Post Acute	1260 E Ohio Avenue Escondido, CA 92027

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to explain the discharge plan to one of two sampled residents (1). As a result, Resident 1 may not have been aware of the scheduled post-discharge appointment with his physician.Findings: Per the facility's admission Record, Resident 1 was admitted on [DATE] with diagnoses to include heart failure, and discharged from the facility on 4/3/26. Per the facility's Discharge Summary and Post-Care Instructions V2.0 dated 4/2/26, Resident 1 was to be discharged to home on 4/3/26 with a scheduled appointment with his primary care physician (PCP) on 4/7/26. On 4/16/26 at 10:05 A.M., an interview was conducted with the Case Manager (CM). The CM stated that she scheduled the appointment with Resident 1's PCP, but did not discuss the PCP appointment with Resident 1 or his family because that was the responsibility of the Licensed Nurse (LN) at the time of discharge. On 4/16/26 at 10:14 A.M., an interview was conducted with LN 3. LN 3 stated, she conducted the discharge for Resident 1, but she did not discuss the scheduled PCP appointment with Resident 1 or his family because that was the responsibility of the CM prior to discharge. On 4/16/26 at 10:21 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, for Resident 1, the CM should have discussed the scheduled PCP appointment with Resident 1 during discharge planning, and LN 3 should have discussed the scheduled PCP appointment with Resident 1 at the time of discharge. The facility's policy, titled Transfer or Discharge, revised March 2025, did not contain instructions on discharge planning, or communicating the discharge plan to the resident.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as ordered for one of four sampled residents (1). As a result, Resident 1 was placed at an increased risk of medication side effects.Findings: Per the facility's admission Record, Resident 1 was admitted on [DATE] with diagnoses to include heart failure, and discharged from the facility on 4/3/26. Per the facility's Medication administration Record for March 2026, Resident 1 had orders for Amlodipine (a medication to lower blood pressure) 5 milligrams (MG), isosorbide mononitrate (a medication to lower blood pressure) extended release 30 MG, and lisinopril (a medication to lower blood pressure) 5 MG. All three medications were ordered to be given every day, but not to administer if Resident 1's systolic blood pressure was less than 110. On 3/1/26 Licensed Nurse (LN) 2 documented that they administered all three medications and that his systolic blood pressure was 106 at the time of administration. On 4/28/26 at 9:04 A.M., a telephone interview was conducted with LN 2. LN 2 stated, she did not remember giving Resident 1 his blood pressure medications while his systolic blood pressure was less than 110. On 4/28/26 at 9:50 A.M., a telephone interview was conducted with the Director of Nursing (DON). The DON stated, LN 2 should have held Resident 1's blood pressure medications when his systolic blood pressure was less than 110. Per the facility's policy, titled Administering Medications dated 2001, 4. Medications are administered in accordance with prescriber orders.6. Medication errors are documented, reported, and reviewed